ANTHRAX VACCINE IMMUNIZATION RECORD

For use of this form see MEDCOM Reg 40-39

SECTION I - ANTHRAX VACCINE INFORMATION CERTIFICATION

1. I have been given an anthrax vaccine information brochure.

2. I have been given the opportunity to ask questions about anthrax vaccine prior to receiving the immunization.

3. SIGNATURE	4. SSN	5. DATE

SECTION II - ADMINISTRATION OF ANTHRAX VACCINE

DATE GIVEN a	DOSE NUMBER b	DOSING SCHEDULE *(from previous dose)* c	DOSE *(ml)* d	SITE *(left or right arm)* e	MANUFACTURER AND LOT NUMBER f	ADMINISTERED BY *(Printed or stamped signature block)* g
	1	Day 0	0.5			
	2	14 days after dose 1	0.5			
	3	14 days after dose 2	0.5			
	4	5 months after dose 3	0.5			
	5	6 months after dose 4	0.5			
	6	6 months after dose 5	0.5			
	Booster	12 months after previous	0.5			
	Booster	12 months after previous	0.5			
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PATIENT IDENTIFICATION *(For typed or written entries give: Name (Last, First, Middle); grade; SSN; hospital or medical facility.)*